FORM 10

Send original to Workers' Compensation Court and 1 copy to Claimant or the Claimant's Attorney of Record

WORKERS' COMPENSATION COURT
1915 NORTH STILES
OKLAHOMA CITY, OKLAHOMA 73105-4918

THIS SPACE FOR COURT USE ONLY

RECEIVED
APR 12 2007
FRASIER, FRASIER & HICKMAN

In re claim of:

Full Name of Injured Employee (Claimant)
ELEAZAR TORRES - GOMEZ (DECEASED)
AMALIA DIAZ - CLAIMANT

Claimant's Social Security Number
584-41-0756

Name of Employer (Respondent)
CINTAS

Employer's Insurance Carrier, Permit # for Court Approved Individual Self-Insured or Own Risk Group, Uninsured
OWN RISK

ANSWER AND PRETRIAL STIPULATION OFFERED BY RESPONDENT

FILE NO.
2007-03253A

Date of Injury
3-6-07

NOTE: Mediation is available to address certain workers' compensation disputes. For information, call (405) 522-8760 or in-state toll free (800) 522-8210.

YES	NO	(Please Type or Print)
X		1. Was claimant at the time of the alleged injury, an employee of the above named respondent?
X		2. Was claimant covered by the Workers' Compensation Act?
	X	3. Did claimant sustain an accidental injury or suffer an occupational disease arising out of and in the course of the employment? (DENIED PENDING INVESTIGATION)
X		4. Has claimant filed a Form 3 within the statutory period of time?
X		5. Did respondent, at the time of the alleged injury, have an own-risk permit or a compensation insurance policy with the carrier named in the caption above?
X		6. Did claimant timely notify respondent of the injury?
	N/A	7. If not, does respondent allege prejudice by such failure?
	N/A	8. Has claimant been provided medical treatment?
	N/A	9. Has respondent commenced payment of temporary total disability payments to claimant? Temporary total disability has been paid to claimant from _____ to _____ for a total of _____ weeks in the total sum of $_____.

(ALL DEPOSTIONS OF MEDICAL EXPERTS SHALL BE COMPLETED PRIOR TO TRIAL)

X 10. Is rate an issue? Claimant's compensation rate: TTD TO BE DETERMINED PPD TO BE DETERMINED

11. State all affirmative defenses: RESPONDENT DENIES ACCIDENTAL INJURY AND DEATH BENEFITS PENDING INVESTIGATION

12. List the names of all witnesses who may be called by respondent at trial: TO BE DETERMINED

13. List all exhibits to be introduced at trial: TO BE DETERMINED

14. Respondent hereby certifies that a copy of the medical report written by Dr. TO BE DETERMINED and dated _____, was mailed, together with a copy of this motion to Opposing party/Counsel.

(LIST ON A SEPARATE SHEET, ADDITIONAL WITNESSES, EXHIBITS AND MEDICAL EVIDENCE)

I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief, they are true, correct and complete. Any person who commits workers' compensation fraud, upon conviction, shall be guilty of a felony.

I HEREBY CERTIFY THAT A COPY HAS BEEN SENT TO:

Opposing Party
J. L. FRANKS / FRANK FRASIER

Address (Number & Street)
P.O. BOX 799

City State Zip Code
TULSA, OK. 74101-0799

Signed this 11th day of APRIL, 2007

Signature of Filing Party
Steven K. Bunting

Address (Number & Street)
15 WEST 6TH STREET, SUITE 2704

City State Zip Code
TULSA, OK. 74119

Telephone # of Filing Party
(918) 592-7030

Print or type name of Attorney OBA #
STEVEN K. BUNTING #1311

EXHIBIT F

Blumberg No. 5118

2/06